Care Management Best Practice:
Care Management Workflow

Implementation of an All Program Care Management Patient Roster and Population Practice Engagement Dashboard

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Background

Oakland Southfield Physicians (OSP) is an association of independently practicing medical group practices serving the tri-county area of Southeast Michigan. Over 77% of the network is pure primary care, including, family practice, internal medicine, and pediatrics. OSP has over 43,000 patients eligible for provider delivered care management, spanning approximately 42 primary care practices. This diverse landscape is presently serviced by a multidisciplinary care management team of 32 care managers.

Executive Summary

- OSP's information technology (IT) team developed an all-program inclusive care management patient roster by practice unit. The *All Program Care Management Patient Roster* assists practices and care managers identify eligible patients for care management.
- OSP's IT team built a care management *Population Practice Engagement Dashboard*, accessible via secure login on OSP's website. This dashboard publishes current rates of patient engagement in active care management programs for individual practices.
- The patient roster and engagement dashboard are unique in that they provide comprehensive patient eligibility for care management payer programs and real-time care management program engagement at a practice level.
- The creation of the patient roster and engagement dashboard has improved the delivery of care management to patients that would benefit from services. OSP has seen a meaningful increase in care gap closure from an average of 76% at baseline in 2016 to 84% in 2018 for practices engaged in Provider Delivered Care Management (PDCM).
- OSP also expanded practice engagement in PDCM from 18 practices in 2016 to 42 practices in 2018. Additionally, overall patient engagement at the physician organization (PO) level increased from 1.24% in 2016 to 3.24% in 2018.

Timeline and Milestones

The initial publication of the *All Program Care Management Patient Roster* was released on June 30, 2016 and included program-specific engagement targets. In coordination with the launch of OSP's new website in 1Q2018, the real time *Population Practice Engagement Dashboard* was introduced. OSP's work on these complementary technologies continues to evolve as we become more sophisticated in the use of shared data.

Goal and Description of Intervention

The goal of the patient roster is to generate a practice-level monthly, all-inclusive care management program patient eligibility list, based on participation in care management programs. Current engagement rates, updated as health plan claims are received, are published on the patient roster as well as on the OSP real-time practice dashboard for transparency on care management activity.

Program Development

OSP's IT team developed the patient roster utilizing health plan patient eligibility rosters and claim code capture. OSP's affiliated care managers directly influenced the creation of the roster by providing suggestions for information that should appear on the roster to improve patient targeting. OSP's IT team

continues to work with our care managers to make improvements and provide pertinent patient information for enhanced targeting and patient engagement.

Program Description

The *All Program Care Management Patient Roster* provides patient eligibility at a practice level for all active care management programs. In addition to demographics, the roster also includes selected chronic conditions and patient engagement status (i.e. partial or full engagement). The number of emergency department/inpatient visits over a rolling 12 months can also be found on the roster. This comprehensive and tailored roster has allowed care managers to take a more valuable and strategic approach to patient targeting for engagement.

The real time *Population Practice Engagement Dashboard* on OSP's website allows individual practices to securely access their current engagement rates in each care management program (see Figure 1 in Appendix). Claims that OSP has received with a paid status are included in the dashboard measurements.

OSP has successfully calculated engagement targets based on annually updated program requirements. In 2019, OSP updated the engagement calculations for PDCM to separate core patient engagement and overall patient engagement. Core engagement rate has a goal of 1% and encompasses commercial BCBSM members who have two care management encounters billed on different dates of service using the twelve core care management codes. The overall engagement rate has a goal of 3% and includes the MA-PPO population with commercial members. Additionally, the overall engagement calculation allows for one care management code to be a medication reconciliation or transition of care code as well as the core management codes.

Patient Identification

Patients are identified for the *All Program Care Management Roster* based on eligibility for the individual care management program(s) using criteria provided by the specific health plan. OSP's IT team takes it a step further by adding chronic conditions and IP/ED visits over a rolling 12-month period. Using the patient roster, OSP affiliated care managers can filter and sort the list to gain a better understanding of those patients eligible for care management.

Measurement

Success was measured based on practice and patient engagement in care management. These metrics were process-based as the consolidated roster and engagement tracking has allowed us to expand services to additional practices and patients. Our workflow has been fine-tuned so that practices and care managers can access their real time engagement rates on demand using our secure website.

Program Results

The results of implementing the *All Program Care Management Roster* and *Population Practice Engagement Dashboard* include expansion of PDCM into additional practice sites as well as increased patient engagement.

OSP has seen a linear growth rate for both PDCM practice engagement as well as patient engagement from 2016 through 2018 (see Graphs 1 & 2 in the Appendix). The increase in patient engagement is even

more meaningful as the rules of engagement became more difficult to achieve after 2016 with the requirement of 2 touches per patient on separate dates of service.

By tailoring the data received from health plans, OSP has improved methods of patient targeting for enrollment into care management. One strategy we focused on more heavily in 2018 is care gap closure for eligible patients. Patients engaged in care management at PDCM practices in 2018 had a higher overall percentage of care gap closure than patients at non-PDCM practices (see Graph 3 in Appendix).

Implementation Tools

Several new tools, processes and resources to support the program include, but are not limited to:

- The *All Program Care Management Roster* is available in both PDF and Excel files. The Excel version allows users to sort and filter the roster for a more targeted approach. OSP's IT department consumes available health plan data such as diagnoses, care management code paid claims, and rolling 12-month inpatient and emergency department visits to publish on the roster. The roster can be filtered by care management program, patient engagement status, chronic conditions, number of inpatient visits, and/or number of emergency department visits.
- The *Population Practice Engagement Dashboard* was added to OSP's secure website and allows access for authorized users from their respective practice sites.

What are you proudest of regarding submission? Why does this work matter?

The intention of the care management roster was to coordinate activity across multiple care management programs for individual practice sites. The implementation and updates of these technologies is disseminated at OSP sponsored monthly care management meetings, as well as biweekly webinars, targeting office managers and care managers. Widespread utilization of the comprehensive roster has made the work worthwhile and instilled pride.

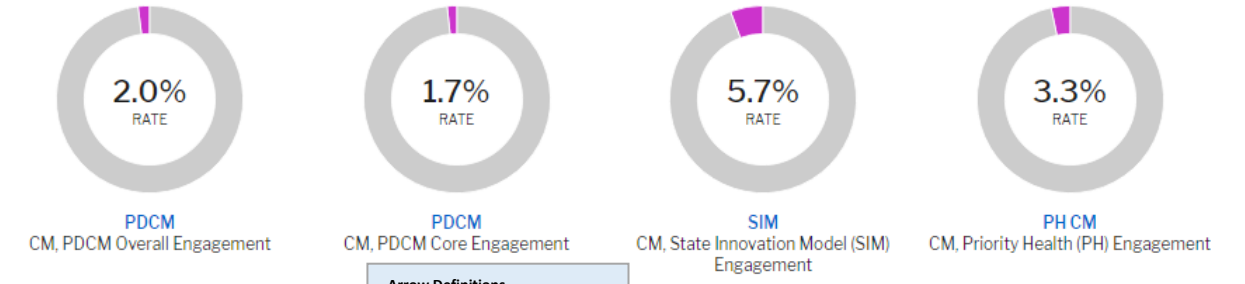
Additionally, creation of the roster was directly influenced by the end users as our care managers expressed interest in having the included details available in one document. For instance, we have been able to assist pediatric practices with patient targeting by adding elevated BMI diagnosis codes to the list of chronic conditions. OSP is also proud of our sophisticated IT development in the calculation of both real time engagement targets published on the *Population Practice Engagement Dashboard* as well as internal prospective targets which include billed encounters that have not been paid yet.

Fund Utilization

If awarded, OSP will utilize the funding to further advance risk stratification methods for purposeful population selection for care management. We intend to align high risk, high benefit population segments with self-imposed patient activation scores for readiness to better engage patients. In addition, OSP will continue to expand care management services into additional practice sites and perform more research and development to innovate methods for improving performance metrics.

Appendix

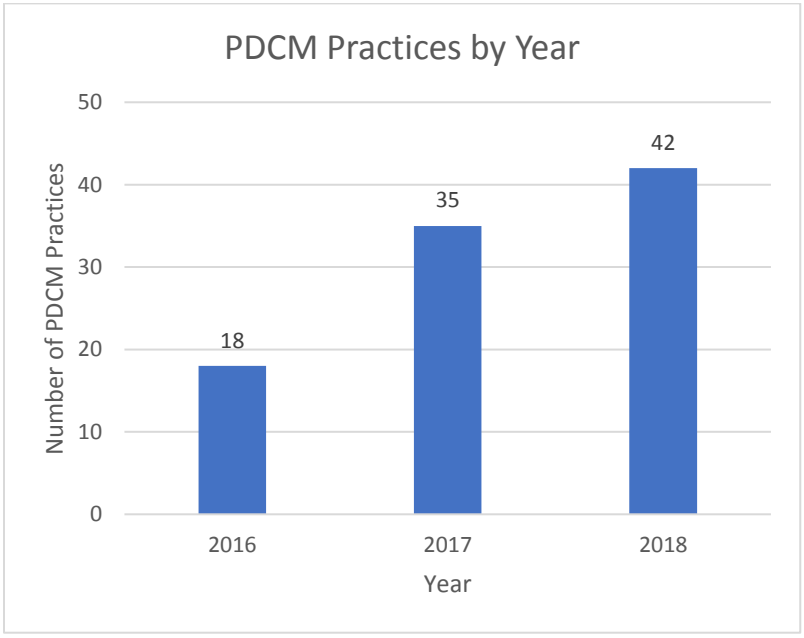
Figure 1. Population Practice Engagement Dashboard



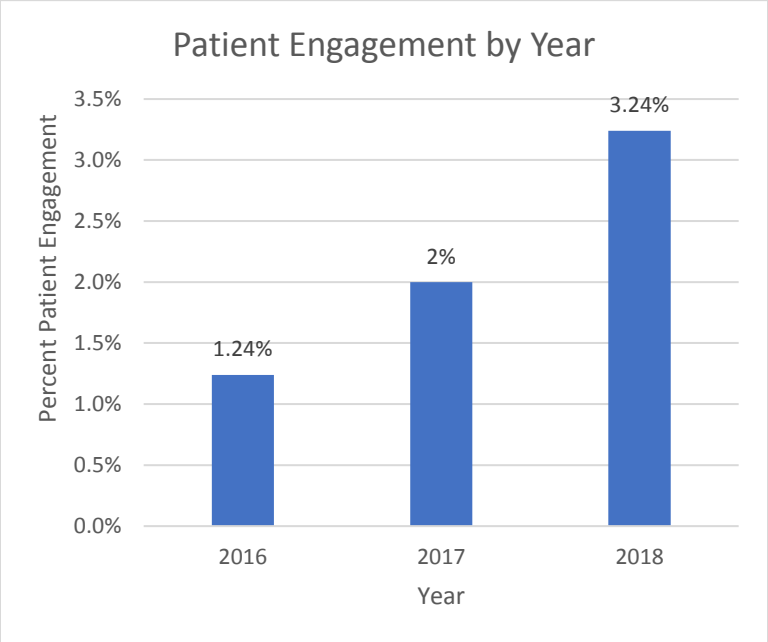
Arrow Definitions
Up = Higher is better
Green = Met target
Yellow = 80% of the way to target
Red = Below 80% of the target

MEASURE NAME (LATEST AVAILABLE DATA)	STATUS	RATE	TARGET	NUMERATOR	DENOMINATOR
CM, PDCM CORE ENGAGEMENT	▲	1.7 %	1 %	12	699
CM, PDCM OVERALL ENGAGEMENT	▲	2.0 %	3 %	15	744
CM, PRIORITY HEALTH (PH) ENGAGEMENT	▲	3.3 %	4 %	5	150
CM, STATE INNOVATION MODEL (SIM) ENGAGEMENT	▲	5.7 %	3 %	9	159

Graph 1. PDCM Practices by Year



Graph 2. Patient Engagement by Year



Graph 3. Average Care Gap Closure